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ABSTRACT

This paper reviews the research on factors that contribute to or protect from the development of antisocial behavior in children, especially those with attention deficit/hyperactivity disorder (ADHD) and learning disabilities (LD). It also presents a model to promote prosocial behavior. General risk factors that put all children at risk for antisocial behavior are identified, such as individual risk factors related to personality, temperament, and cognitive ability and family/community/societal risk factors. Risk factors that are specific to children with ADHD and LD are identified, such as individual characteristics and innate traits, academic failure, social failure, emotional impairment, differential treatment, and low self-esteem. Children with ADHD and LD are reported to be at special risk for oppositional defiant disorder, conduct disorder, and delinquency. The report also considers resiliency in overcoming risk, noting general protective factors (such as good schools) and specific protective measures for children with ADHD and LD (multidisciplinary intervention). The importance of the child's attachment to at least one prosocial supporting adult is stressed for the promotion of prosocial behavior. Recommendations for policy and practice address risk reduction; cultivation of resiliency; encouragement of bonding; increased self-esteem; and creation of a consistent system of expectations, reinforcement, and recognition. (Contains 89 references.) (CR)

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Preventing Antisocial Behavior in Disabled and At-Risk Students

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The public expects schools to socialize children as well as to educate them.[1] In fact, socialization, rather than academics, is why many parents choose public education over private or home school. However, public criticism of schools' performance in both roles has increased in recent years. The public wants schools to be responsible not only for improving achievement but also for curbing disruptive, violent, and antisocial behavior. As a result, support is growing for "zero tolerance" discipline policies and alternative school placement for disruptive students.

Discussions about discipline have especially focused on special education students. Some teachers and parents are against the inclusion of potentially disruptive students in regular education classrooms and schools. They want to change laws and policies that discourage exclusion, suspension, and expulsion of such students. However, for children suffering from disabilities and other risk factors like poverty, crime, and abuse, traditional discipline methods and policies may exacerbate rather than remedy problem behavior.[2]

Discipline reacts to behavior that has already occurred. Schools may also need to focus their efforts on prevention. David Hawkins, professor of social work and director of a 10-year delinquency prevention study at the University of Washington in Seattle, worked as a probation officer in the 1970s. He says,

> Dealing with [delinquent teenagers] as a probation officer, I saw my job something akin to operating an expensive ambulance service at the bottom of a cliff. The probation staff were the emergency team patching up those who fell over the edge. Many of us who have worked in juvenile corrections have come to realize that to keep young people from falling in the first place, a barrier is needed at the top of the cliff. In short, we believe that prevention is more effective and less costly than treatment after the fact.[3]

Research has identified risk factors that contribute to the development of antisocial behavior as well as protective factors that help children develop resiliency to overcome risk. This paper examines the research on these factors, especially in regard to Attention Deficit/Hyperactivity Disorder (ADHD) and learning disabilities (LD); presents a model that promotes prosocial behavior; and suggests considerations for preventive practice and policymaking.

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Risk and Antisocial Behavior

Research shows that most antisocial behavior develops from a combination of risk factors associated with individuals, families, schools, and communities.[2,3,4] The same factors apply across races, cultures, and classes, and their effects are cumulative—exposure to multiple and interacting risk factors exponentially increases a child's overall risk.[3,4] Also, antisocial behavior evolves over the course of childhood, often beginning in the preschool and elementary years and peaking in late adolescence/early adulthood. Direct, early intervention can halt its progress; once firmly established, however, antisocial patterns become more difficult to change and can persist into adulthood.[2,4]

General Risk Factors for Antisocial Behavior

Several general factors put all children at risk for antisocial be-

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havior, including children disabled by ADHD and LD. The presence of multiple factors increases risk; conversely, their elimination reduces risk.

Individual risk factors. Several inborn traits and characteristics related to personality, temperament, and cognitive ability have been identified as risk factors for later delinquent behavior. These do not doom children to misbehavior or crime, but they do make them more susceptible to other risks in the environment. In addition, several factors other than inborn traits are known to place individuals at risk. (See box.)

Family/community/societal risk factors. Family characteristics, as well as community and societal factors, can increase risk for antisocial behavior. (See box.)

School-related risk factors. An array of school factors can be linked to delinquent behavior. (See box.)

Chronic school failure demoralizes children, can cause loss of status and rejection by peers, destroys self-esteem, and undermines feelings of competence. As a result, it can undermine a child's attachment to teachers, parents, school, and the values they promote. It also generates hopelessness and helplessness. Children cease to believe that their efforts make a difference in outcomes.[12,13,14] For delinquent youngsters, "school is not a place of attachment and learning, but of alienation and failure."[15]

In addition, an analysis of disruptive behavior in 600 schools revealed that schools with discipline problems tend to be large and urban; lack teaching resources; lack fair, clearly stated, consistently enforced rules; have students who do not believe in the rules; lack leadership and cooperation among staff; and have punitive teachers.[16] One study found punishment and lack of praise by classroom teachers to be main factors related to delinquent behavior.[17]

Risk Factors for Antisocial Behavior

Individual

Impulsivity; the inability to adopt a future time perspective or to grasp future consequences of behavior; the inability to delay gratification; the inability to self-regulate emotions, especially temper; the need for stimulation and excitement; low harm avoidance; low frustration tolerance; central nervous system dysfunction; low cortical arousal; a predisposition to aggressive behavior; low general aptitude or intelligence; exposure to violence and abuse (as either a victim or a witness); alienation; rebelliousness; association with deviant peers; favorable attitudes toward deviant behavior; peer rejection; alcohol and drug abuse; and early onset of aggressive or problem behavior.[2,3,4,5,6,7,8,9,10]

Family/Societal

Economic deprivation and unemployment that limit access to food, shelter, transportation, health care, etc.; parental history of deviant behavior; favorable family/community attitudes toward deviant behavior; harsh and/or inconsistent discipline; poor parental and/or community supervision and monitoring; low parental education (especially maternal education); family conflict; disruption in care giving; out-of-home placement; poor attachment between child and family; low community attachment and community disorganization, as evidenced by low parent involvement in schools, low voter turnout, and high rates of vandalism and violence; parental alcoholism; social alienation of the community; availability of drugs and guns; high community turnover; and exposure to violence, including violence in the home, community, and media.[2,3,4]

School-based

Academic failure beginning in elementary school; poor academic aptitude test scores—especially in reading—beginning in Grades 3 and 4; lack of commitment to school; lack of belief in the validity of rules; early aggressive behavior (in Grades K-3); lack of attachment to teachers; low aspirations and goals; peer rejection and social alienation; association with deviant peers, including grouping antisocial children together for instruction and/or punishment; low student/teacher morale; school disorganization; ineffective monitoring and management of students; and poor adaptation to school, as evidenced by retention and attendance rates, assignment to special education, and student reports of not liking school, lack of effort, alienation, and punishment.[2,3,4,11]

Risk Factors Specific to ADHD and LD

Children with inadequately treated ADHD and LD are especially at risk for developing antisocial behavior—oppositional defiant disorder, conduct disorder, and delinquency.[3,5,6,18,19] Those with ADHD experience "high rates of suspension and expulsion from school,"[20] 50 to 70 percent develop oppositional defiant behavior, and 20 to 40 percent show symptoms of the more serious conduct disorder.[21,22]

Wexler estimates that up to 70 percent of juvenile offenders and 40 percent of adult prisoners may have ADHD[7]—a significant percentage, considering that only three to seven percent of the general population have ADHD.[23] Likewise, from 30 to 50 percent of adjudicated juveniles and adults have been found to have LD, compared to a five to ten percent prevalence in the general population.[8] Learning disabilities increase a child's risk of adjudication by 220 percent.[5] Studies of children with ADHD reveal that 23 to 45 percent have juvenile convictions.[24] The relationship between ADHD and antisocial behavior is so strong that some consider ADHD to be a predisposing risk factor.[3,6,8,25]

ADHD and LD represent not one risk factor but a constellation of pervasive, interacting factors that multiply risk. The underlying neurological dysfunctions that cause these disabilities impair performance in cognitive, social, and emotional domains.[18,26,27,28] This impairment too often snowballs into academic and social failure and, ultimately, into behavioral and affective disorders—unless the environment eliminates compounding risk factors and puts protective factors in place to prevent it. The following specific risk factors contribute to negative outcomes.

Individual characteristics and innate traits. Most of the individual traits associated with risk (listed above) characterize many children with ADHD and/or LD.[2,3,5,6] Recent brain imaging studies of children with ADHD support previous evidence of underarousal and impairment in frontal regions of the brain thought to help individuals monitor and control behavior, strategize, and set goals.[29,30] In addition, children with ADHD have been shown to be less responsive than other children to environmental feedback—reinforcement, consequences, and punishment.[31] Finally, some children with ADHD and reading disabilities may also be predisposed to aggression.[31,32]

Unfortunately, ineffective and punitive responses . . . have taught many antisocial children "that they do not like school . . . and that following conventional rules does not yield rewards."

These traits may be physiologically and biologically based and therefore resistant to change. However, as Goleman points out, "genes alone do not determine behavior; our environment, especially what we experience and learn as we grow, shapes how a temperamental predisposition expresses itself as life unfolds."[33] Unfortunately, ineffective and punitive responses from their environments have taught many antisocial children "that they do not like school or their parents and that following conventional rules does not yield rewards."[34]

Academic failure. Cognitive impairments in children with ADHD and LD frequently cause serious academic problems—low reading scores, language impairment, and poor grades.[35] If unaddressed, these impairments increase the risk of school failure, amplifying any innate risks for developing antisocial or delinquent behavior.[2,3,4,5,6,36]

Social failure. Despite their social natures and prosocial intent, 50 to 80 percent of children with ADHD and LD experience significant peer problems and social failure.[37,38,39,40] They tend to be lonelier, have fewer friends, and participate in fewer extracurricular and community activities than their nondisabled peers. Social problems are so prevalent in children with ADHD that some consider them a hallmark characteristic.[37]

For disabled children, "reading" social cues may be as difficult as reading words.[41] Both academic and social tasks require children to process and respond to cues and information in the environment, but unlike books, which are inanimate and static, interpersonal communications are dynamic and emotionally charged. Subtle nonverbal cues, timing, and affect—facial expression, posture, and tone and volume of voice—can determine how others interpret meaning and perceive intent. Disabled

children are more likely to misperceive or miss social cues and to perceive hostile intent where it doesn't exist.[28,42] On the other hand, they are less likely to "get" jokes or to discern when others are joking.[43]

Lack of inhibition can cause children with ADHD to behave tactlessly and intrusively, dominate and interrupt conversations, and not listen.[43] As a result, they may be seen as obstinate, bossy, insensitive, and rude.[28,40,42,44] Finally, many children with ADHD and LD have significant impairment of the skills needed to modulate behavior in response to changing demands, and so their behavior may often seem inappropriate for a particular situation.[27,40,47]

Recent studies of children with ADHD with normal I.Q.s revealed below average scores on the Vineland Adaptive Behavior Scale[48]—an assessment usually used for students with developmental disabilities. The children scored poorly in subtests of socialization, communication, and daily living.[49] Surprisingly, the discrepancy between adaptive behavior and intelligence worsened, rather than improved, with age, underscoring the need for early intervention and treatment.[50]

Emotional impairment. Children with ADHD and LD may exhibit poor emotional regulation, resulting in outbursts, temper tantrums, overreaction, impatience, and limited self-awareness.[43] The lack of emotional control increases the risk of behavior problems, anxiety, and depression.[28]

In addition to prevalent conduct problems, 20 to 30 percent of children with ADHD experience anxiety disorders and up to 75 percent experience depression.[20,28] Chronic stress at school and home can interfere with academic performance by destroying brain cells and impeding brain functions involved in learning and memory.[51,52] Schools that are "highly evaluative and authoritarian" increase such nonproductive stress.[53]

Differential treatment. Children with ADHD and LD are more likely to be arrested and convicted than their nondisabled peers for the same delinquent behaviors.[5] This may be because they lack the cognitive and language skills to avoid detection, conceal intent, and respond to questions and warnings by police. It may also be due to poor social skills and emotional regulation. Children with ADHD and LD tend to be "awkward and abrasive in social interactions. Demeanor of the arrestee is an extremely important factor in determining whether an arrest will be made in routine encounters with the police."[54]

The majority of children do well in life despite adversity and exposure to multiple risks.

Captain Susan Rahr, commander of the Gang Suppression Unit in Seattle, Washington, agrees that poor social skills can contribute to higher arrest rates for children with ADHD. Her experience shows that a child's social skills play a part in determining whether police take an offending child home to parents or to the station for booking, thus beginning a juvenile record. The child who can "fake the socially desirable response"[54] is more likely to be taken home; the child who responds inappropriately is more likely to go to jail for the same offense (Rahr, personal communication, November 9, 1995).

A similar phenomenon may occur in schools, contributing to high rates of punishment, suspension, and expulsion for children with ADHD and LD. Research shows that children with ADHD elicit more negative reactions from teachers, parents, and other adults, and can cause more negative treatment for an entire classroom of students.[37,38]

Low self-esteem. Brooks explains that "assaults to their self-worth as a consequence of the behaviors associated with ADD" cause children "to believe that their mistakes and failures are some kind of 'character flaw,' a flaw that cannot be modified. The result of such thinking is a child who may give up and resort to ways of coping that are ineffective and self-defeating."[55] Goldstein and Goldstein state that the child with ADHD is more at risk for oppositional behavior because he "often cannot meet the demands of others, he fails frequently, and as a result becomes frustrated, unhappy, and more negative."[56] Fouse and Brians suggest that well-meaning but "frustrated parents and teachers may push these children to the brink of despair."[57] Some think that the defiant child may be fighting for self-preservation, while the depressed child has given up.

Resiliency: Overcoming Risk

The majority of children do well in life despite adversity and exposure to multiple risks.[3,59] Children who are able to thrive despite risks are said to be resilient.[3,13,58,59,60,61,62,63] Researchers have identified certain protective factors that—like barriers at the tops of cliffs—can help promote resilience and prevent negative outcomes.

General Protective Factors

Protective factors, like risk factors, can be located within individuals, families, communities, and schools. They apply to all children, including those who are disabled and otherwise at risk. The effects of these factors are cumulative—the more factors present, the greater their influence.[4]

Individual traits. Resilient children tend to be socially competent, autonomous, not easily frustrated, able to bounce back, not quick to give up, good natured, optimistic, intelligent, appealing to adults, and able to elicit positive attention and support. They have good problem-solving skills, a sense of purpose and personal control, a future orientation, and high self-esteem.[3,4,13,58,59,64] Resilient children learn to define themselves by their strengths and talents rather than their weaknesses, are valued by others for their talents, develop a sense of personal mastery, and contribute to society by performing socially desirable tasks.[13,60] Females in general have less proclivity for disruptive behavior.[3]

Families/communities. Families of resilient children exhibit warmth, affection, and emotional support.[4,13] Children and parents or caretakers form mutual attachments, and children are monitored and supervised. Likewise, communities can nurture, monitor, supervise, and convey prosocial values to children.

Schools. Rutter says, "Schools that foster high self-esteem and promote social and scholastic success reduce the likelihood of emotional and behavioral disturbance."[65] These schools, according to Benard, "establish high expectations for all students"—including those with disabilities—and provide students "the support necessary" to achieve them.[66] They convey compassion, understanding, respect, and interest for children and families; and present opportunities for meaningful participation. They identify children's strengths and talents—their "islands of competence"[14]—and organize learning accordingly, incorporating learning styles, multiple intelligences, and an accelerated, rich curriculum that includes art, music, and athletics. They design classroom instruction to accommodate various ability levels, and maximize learning time.[3,59,60,61,62]

Schools that foster high self-esteem and promote social and scholastic success reduce the likelihood of emotional and behavioral disturbance.

Research shows that school organization—management, governance, culture, and climate—can reduce overall measures of student disruption as effectively as individual treatment programs.[11,67] Effective schools involve "community agencies, students, teachers, school administrators, and parents" in decisionmaking,[68] and focus "on improving communication, building trust and cooperation, enhancing the organization's problem-solving and decision-making capabilities, and strengthening [the] planning process."[69] Through cooperation and collaboration, schools can draw on internal and community resources to meet students' needs.

Other school-related, protective factors identified through research include boosting achievement in mathematics and reading (especially 4th-grade reading scores), commitment to school, and attachment to teachers.[59,61,70]

Specific Protective Measures for ADHD and LD

Because of the pervasive effects of ADHD and LD on cognitive, social, and emotional performance, disabled children may require specific interventions in addition to schoolwide protective factors. These should be multidisciplinary and multimodal—involving parents, teachers, medical and mental health professionals, and other support personnel in schools and communities—in addressing the whole child's needs: academic, social, emotional, and physical.[4,18] Multimodal treatment has been

shown to dramatically reduce antisocial behavior by reducing risk factors.[71]

For disabled children, comprehensive assessment and individualized education programs (IEPs) can help identify and maximize children's strengths while detecting and accommodating weaknesses that add to risk. Although schools cannot change underlying neurological impairments that affect children's cognitive, social, and emotional performance, they can help prevent impairments from causing academic and social failure by providing appropriate accommodations and early intervention.

Children with ADHD and LD have many strengths that can help them learn. They can be very intelligent, funny, social, energetic, passionate, and highly talented in art, music, and athletics. Children with ADHD exhibit many characteristics attributed to creativity and giftedness.[72,73,74] Studies have shown them to be adept at imagery and symbolism, able to assimilate information by scanning, and able to process information below the threshold of consciousness.[73,74] High-IQ children with ADHD are better than similar non-ADHD children at nonverbal problem solving and score higher on measures of nonverbal creativity.[74]

To succeed in school, many disabled children need to learn strategies for improving social performance and controlling emotions.[3,28,75,76] Early intervention programs to improve social competence and meet physical and emotional needs have been shown to increase academic achievement and to prevent later delinquent behavior.[77] Other programs to teach coping strategies, and academic, social, and life skills to disabled juvenile and adult offenders have been shown to substantially improve behavior and reduce criminal recidivism rates.[8,78] A remedial program for juvenile offenders with previously undetected disabilities reduced recidivism rates to an astounding two percent.[79]

Although research on the effectiveness of social-skills training with ADHD-diagnosed children is contradictory and inconclusive, several school-based programs have been successful in helping children learn social competence and emotional regulation.[3,28,77] Goleman believes that school-based programs to teach "emotional literacy" can help children learn to control impulses and emotions, especially anger and aggression, and develop self-awareness.[28] To be most effective, programs should begin early—even during the preschool years; be integrated into the context of daily school life; provide immediate, salient reinforcement and feedback, including lots of praise for appropriate behavior; and use simulations, role-playing, and other hands-on, experiential methods to rehearse real-life experiences.[80] School activities that emphasize social interaction—cooperative learning, field trips, drama, dance, music, and physical education—provide opportunities for developing social competence while learning, and instruction that incorporates metacognitive activities helps students increase self-awareness.[32]

Early intervention programs to improve social competence and meet physical and emotional needs have been shown to increase academic achievement and to prevent later delinquent behavior.

To boost self-esteem, children need support in opportunities to develop responsibility; to contribute to school, family, and community life; to make decisions and choices; to nurture self-discipline; and to deal with failure and mistakes.[32] These help build feelings of self-competence, restoring children's belief that their efforts can make a difference in their lives.

A Model for Promoting Prosocial Behavior

Perhaps the most critical factor influencing the development of prosocial behavior is attachment to at least one prosocial adult who believes in the child and provides unconditional acceptance and support.[3,12,13,59,60] Hawkins explains that prosocial behavior results when children bond with prosocial adults and peers and adopt their beliefs and values.[3] Conversely, antisocial behavior results if children bond to antisocial individuals, such as gang members, and adopt their beliefs and values instead.

For bonding to occur, three conditions must be present:

- an opportunity for bonding to take place;

- cognitive and social skills to help children succeed in bonding opportunities; and
- a consistent system of recognition and reinforcement for accomplishments.[3]

A resilient temperament, social competence, and cognitive skills are protective factors that help children participate successfully in prosocial bonding opportunities. Recognition reinforces what children are doing right, plus provides an incentive to persist in bonding activities and relationships.

Many experts agree that attachment to even one caring, responsible adult—whether a teacher, administrator, bus driver, custodian, relative, or community member—can help children become prosocial.[3,12,13,58,60] A study of the effects of remediation on delinquency showed that the child's bond with the tutor affected school attitude and behavior more than improved grades.[5]

The important role of bonding in the development of prosocial behavior offers schools an avenue for effective prevention and intervention. Mentoring and similar one-on-one programs and group activities can help children develop relationships that foster self-esteem, social attachment, and prosocial behavior. A promising new strategy for individuals with ADHD pairs children with "coaches" who help define goals, objectives, and plans to achieve them, while providing support and encouragement.[81,82]

Children seek to imitate and gain approval from their role models, whether good or bad. Once children bond with antisocial peer groups, their behavior becomes more difficult to change. Schools, families, and communities can work together to ensure that all children are cared for and have prosocial adults to emulate, thus assuring the transmission of prosocial beliefs and values to the next generation.

Perhaps the most critical factor influencing the development of prosocial behavior is attachment to at least one prosocial adult who believes in the child and provides unconditional acceptance and support.

Prevention: Policy and Practice

Gottfredson says that "the task of educating and socializing children requires that [schools] be arranged in ways that successfully produce the desired result."[83] To improve student behavior and school safety, policy must address prevention as well as treatment of misbehavior and support practices that both reduce risk and cultivate resilience in children.

Reducing risk

Reducing risk requires a collaborative, comprehensive effort to consider and minimize individual, family, community, and school-based risk factors. Each of these facets of risk suggests broad areas for preventive policy action: school organization and effectiveness, student achievement and early intervention, parent/community partnership, and professional development. (See box, p. 8.) For example, one such action could be to require schools to assess risk as a component of safe schools or school improvement plans; however, specific strategies for reducing risk must be tailored to unique student, school, and community needs.

In his "Communities that Care" model, Hawkins suggests the following steps to systematically minimize risks:

- develop a vision and goals,
- assess existing risk factors,
- collect data on current efforts to address them,
- create an action plan to target unaddressed risks, and
- develop a way to evaluate results.[3]

Cultivating resiliency

Policies and practices that promote the transfer of prosocial behavior and beliefs to children (1) maximize opportunities for bonding; (2) increase academic, social, and emotional competence and self-esteem; and (3) create a consistent system of expectations, reinforcement, and recognition to shape behavior.[3]

Maximizing opportunities for bonding. If students are to form attachments to school and prosocial role models, then policies and practices should ensure that teachers, students, parents, and communities have the time and means to get to know each other. For example, policy ac-

Areas for Preventive Policy Action: Does policy encourage prevention of problem behavior?

I. **School Organization and Effectiveness** (management, governance, culture, and climate)

- Do schools involve teachers, students, parents, and community members in decisionmaking?
- Do schools have high expectations for learning and behavior for all children and help all children achieve them?
- Do schools clearly communicate expectations for learning and behavior to students?
- Do schools have a consistent system of reinforcement and recognition to help shape behavior?
- Do schools provide alternatives to suspension and expulsion?
- Do school practices promote student engagement and attachment?
- Do schools conduct risk assessment as part of safe schools/ school improvement plans?

II. **Student Achievement/ Early Intervention**

- Do schools intervene early to identify and assist students who fail to meet expectations for learning and behavior?
- Do schools evaluate students' social, emotional, and adaptive functioning, as well as cognitive functioning, as part of multidisciplinary evaluation?
- Do IEPs address social, emotional, and adaptive problems as well as academic problems?
- Do schools provide assistance to nondisabled students with learning and behavior problems?
- Do schools include special education students in regular education classrooms?
- Do schools include special education students in performance accountability measures: statewide testing, attendance, and dropout rates?
- Do schools disproportionately discipline students with disabilities?

III. **Parent/Community Partnerships**

- Do schools work with parents and communities to educate and care for children?
- Do schools involve parents/ communities in safe schools/ school improvement plans?
- Do schools provide information to parents about how to help their children learn and behave appropriately in school?
- Do schools collaborate with other agencies to meet family/ community needs?

IV. **Professional Development**

- Have teachers been trained to use a variety of instructional and classroom management strategies to prevent academic failure and problem behavior with all children, including those with disabilities?
- Do preservice programs in state schools of education provide this training?
- Have state department of education inservice programs provided this information?

tions might involve extending the school year or the school day, revising consolidation plans and class size limits, adding community service to graduation requirements, or creating a program to assign personal coaches or mentors for students with IEPs or recurring discipline referrals. Related school practices might include improving school attendance, looping (teachers and classes stay together for two or more years), block scheduling, teaming, cooperative learning, mentoring or coaching, and one-on-one tutoring.[61,70,84,85]

Policies and practices that support prosocial bonding do not isolate and alienate children unnecessarily through tracking, special education placement, suspension, or expulsion, and do not encourage the formation of deviant peer groups by placing "problem" children together for instruction or discipline.

Increasing academic, social, and emotional competence and self-esteem. Because social, emotional, and cognitive skills are essential for achieving academic and behavioral expectations, policies that support the development of personal competence and self-esteem should provide the impetus to identify and address the whole child's needs. For example, multidisciplinary evaluation to determine exceptionality—especially ADHD and LD—should include assessment of adaptive, social, and emotional functioning as well as cognitive functioning.

Policy actions should encourage and support practices that allow for student diversity— different ways and rates of learning, as well as strengths, talents,

and weaknesses. For instance, preserving budgets for athletics and the arts not only supports achievement[86] but also provides opportunities for children to develop and showcase strengths and talents that foster resilience,[61] increase self-esteem, and boost social standing.[13] Use of individual instruction, alternative assessments, cross-age grouping, and well-designed supplemental and resource programs; and attention to multiple intelligences and learning styles allow children to achieve basic skills at their own rates while avoiding the negative outcomes associated with retention.[59,87] Cooperative learning groups, conflict resolution and anger management training, group activities, and counseling help children to learn alternatives to antisocial behavior, to deal with their emotions, and to get along with others.

Creating a consistent system of expectations, reinforcement, and recognition. Environments that get desired results define desired and undesired behavior, determine when they occur, and apply consequences—rewards and punishments—that influence the rate at which they are displayed.[2] Such environments establish high expectations for all students; a clear system of rules and consequences that are consistently, fairly, and equitably enforced; and cooperative, collaborative, and caring climates.[11,67]

State policy can influence whether school discipline systems balance traditional reactive and punitive measures with proactive and preventive ones. For instance, preventive systems create alternatives to suspension and expulsion—like community service—for all but the most serious offenses, to keep from further isolating and alienating children who are already marginally attached to the school culture. Policy can also promote equity in expectations and treatment for poor, minority, and disabled children by focusing attention on performance indicators for at-risk groups. For example, including children with disabilities in statewide testing and aggregating their attendance, suspension, expulsion, and dropout rates can provide accountability data to policymakers and help to evaluate program effectiveness and school reform efforts.[88]

. . . preventive systems create alternatives to suspension and expulsion—like community service—for all but the most serious offenses, to keep from further isolating and alienating children . . .

Although state policies define standards for learning and behavior, local school practices determine whether students have the means to achieve them. Strategic planning for school improvement, shared decision-making, and collaboration among school and related staff, families, and communities help design and build the structure children need to achieve state standards and meet academic and behavioral expectations.[89]

Conclusion

No silver bullet can eliminate behaviors resulting from neurological impairment, disadvantage, and social disintegration. But those who care for the nation's children—schools, families, and communities—can pull together to consider what is going wrong and what can be done to prevent it, based on solid knowledge of how children develop antisocial or prosocial behavior. By identifying both risk factors and protective factors, research has given us the tools to build solutions—barriers at the tops of cliffs that keep children from falling—and has restored our hope that we, collectively and individually, can make a difference.

References

1. Clune, W. (1995). *Education finance in the 21st century: Productive education through adequacy and efficiency.* Paper prepared for the NEA State Finance Workshop, May 18-19, Denver, CO.
2. Gottfredson, G. (1987). American education: American delinquency. *Today's Delinquent* (pp. 5-70). Pittsburgh, PA: National Center for Juvenile Justice.
3. Hawkins, J. (1995). Controlling crime before it happens: Risk-focused prevention. *National Institute of Justice Journal, 229,* pp. 10- 18.
4. Thornberry, T. (1994). Risk factors for youth violence. In L. McCart (Ed.), *Kids and violence* (pp. 8-14). Washington, DC: National Governors Association.
5. Keilitz, I., & Dunivant, N. (1986). The relationship between learning disability and juvenile delinquency: Current state of knowledge. *Remedial and Special Education, 7*(3), 18-26.

6. Martinez, A., & Bournival, B. (1996). ADHD: The tip of the iceberg? *The ADHD Report, 3*(6), pp. 5-6.

7. Wexler, as cited in Wexler, H. (1996). AD/HD substance abuse and crime. *Attention, 2*(3), pp. 27-32.

8. Brier, N. (1994). Targeted treatment for adjudicated youth with learning disabilities: Effects on recidivism. *Journal of Learning Disabilities, 27*(4), 215-222.

9. Wright, L. (1995, August 7). A reporter at large: Double mystery. *The New Yorker*, pp. 45-62.

10. Gibbs, W. (1995). Trends in behavioral science: Seeking the criminal element. *Scientific American, 272*(3), pp. 100-107.

11. Gottfredson, D. (1986). *Promising strategies for improving student behavior.* Paper prepared for the Conference on Student Discipline Strategies of the Office of Educational Research and Improvement. Washington, DC: U. S. Department of Education.

12. Brooks, R. (1994). Enhancing self-esteem in children and adolescents with ADHD. *The ADHD Report, 2*(3), pp. 8-9.

13. Brooks, R. (1994). Children at risk: Fostering resilience and hope. *American Journal of Orthopsychiatry, 64*(4), 545-553.

14. Brooks, R. (1992, Fall, Winter). Fostering self-esteem in children with ADD: The search for islands of competence. *Chadder*, pp. 14-15.

15. Hawkins, J. (1995). Controlling crime before it happens: Risk-focused prevention. *National Institute of Justice Journal, 229*, p. 10.

16. Gottfredson & Gottfredson (1985), as cited in Gottfredson, D. (1986). *Promising strategies for improving student behavior.* Paper prepared for the Conference on Student Discipline Strategies of the Office of Educational Research and Improvement. Washington, DC: U. S. Department of Education.

17. Farrington, D. (1987). Schools and delinquency prevention. *Today's Delinquent* (pp. 71-86). Pittsburgh, PA: National Center for Juvenile Justice.

18. Barkley, R. (1995). *Taking charge of ADHD.* New York: The Guilford Press.

19. Accardo, P. (December 1991-January 1992). My child has an attention deficit disorder. Now what? *PTA Today, 17*(3), 17-19.

20. McKinney, J., Montague, M., & Hocutt, A. (1993). A synthesis of the research literature on the assessment and identification of attention deficit disorder. *Education of children with attention deficit disorder* (p. 96). Washington, DC: U. S. Department of Education.

21. Goldstein, S., & Goldstein, M. (1992). *Hyperactivity: Why won't my child pay attention?* New York: John Wiley & Sons, Inc.

22. Barkley, R., as cited in Martinez & Bournival. (1996). ADHD: The tip of the iceberg? *The ADHD Report, 3*(6), pp. 5-6.

23. Edwards, G. (1995). Book reviews: Attention deficits and hyperactivity in children, by Stephen Hinshaw. *The ADHD Report, 3*(1), p.13.

24. Barkley, as cited in Landau, S., & Moore, L. (1991). Social skills deficits in children with attention-deficit hyperactivity disorder. *School Psychology Review, 20*(2), 235-251.

25. Forehand, R., Wierson, M., Frame, C., Kempton, T., & Armistead, L. (1991). Juveni delinquency entry and persi tence: Attention problems cor. tribute to conduct problems. *Journal of Behavior Therapy and Experimental Psychiatry, 22*(4), 261-264.

26. Matazow, G., & Hynd, G. (1992). *Right hemisphere deficit syndrome: Similarities with subtypes of children with attention deficit disorder.* Paper prepared at the Annual Convention of the International Neuropsychological Society, San Diego, CA.

27. Waterhouse, L., Denckla, M., Insel, T., Voeller, K., & Szatmari, P. (speakers). (1994). *Social Competence: A Neurobehavioral Perspective.* Medical Preconference Symposium of the 1994 Learning Disabilities Association International Conference, Washington, DC. (Cassette Recording Nos. G141-W1A-G141-W1D). Garden Grove, CA: Infomedix.

28. Coleman, D. (1995). *Emotional intelligence.* New York: Bantam Books.

29. Kinoshita, J. (1996). Brain abnormal in attention deficit hyperactivity disorder. *BrainWork, 6*(1), p.10.

30. Barkley, R. (1995). Late breaking research news. *The ADHD Report, 3*(6), p.12.

31. Dykman, R., Ackerman, P., & Raney, T. (1993). *Assessment and characteristics of children with attention deficit disorder.* Washington, DC: U. S. Department of Education.

32. Cornwall, A., & Bauden, H. (1992). Reading disabilities and aggression: A critical review. *Journal of Learning Disabilities, 25*(5), 281-288.

33. Goleman, D. (1995). *Emotional intelligence* (p. 224). New York: Bantam Books.

34. Gottfredson, G. (1987). American education: American delinquency. *Today's Delinquent* (p. 22). Pittsburgh, PA: National Center for Juvenile Justice.

35. Murray, as cited in Keilitz, I., & Dunivant, N. (1986). The relationship between learning disability and juvenile delinquency: Current state of knowledge. *Remedial and Special Education, 7*(3), 18-26.

36. Garnett, D. (1994). Dimensions of youth violence. In L. McCart (Ed.). *Kids and violence* (pp. 15-24). Washington, DC: National Governor's Association.

37. Landau, S., & Moore, L. (1991). Social skills deficits in children with attention-deficit hyperactivity disorder. *School Psychology Review, 20*(2), 235-251.

38. Wallander, J., & Hubert, N. (1987). Peer social dysfunction in children with developmental disabilities: Empirical basis and conceptual model. *Clinical Psychology Review, 7*(2), 205-221.

39. Whalen, C., & Henker, B. (1985). The social worlds of hyperactive children. *Clinical Psychology Review, 5*(5), 447-445.

40. Landau, S., & Milich, R. (1988). Social communication patterns of attention-deficit-disordered boys. *Journal of Abnormal Psychology, 16*(1), 69-81.

41. Hallowell, E., & Ratey, J. (1994). *Driven by distraction*. New York: Pantheon Books.

42. Heilveil, I., & Clark, D. (1990, August). *Personality correlates of attention deficit hyperactivity disorder*. Paper presented at the Annual Convention of the American Psychological Association, Boston, MA.

43. Murphy, K. (1994, October/November). Interpersonal and social problems in adults with ADD. *Chadder*. Plantation, FL: Children and Adults with Attention Deficit Disorder.

44. Barkley, R. (1991). *Attention deficit hyperactivity disorder: A clinical workbook* (p. 94). New York: The Guildford Press.

45. Cunningham, C., & Cunningham, L. (1995). Reducing playground aggression: Students mediated conflict resolution. *The ADHD Report, 3*(4), pp. 9-11.

46. Pennington, B. (1991). *Diagnosing learning disorders: A neuropsychological framework*. New York: The Guilford Press.

47. Bender, W. (1995). *Learning disabilities*. Boston: Allyn and Bacon.

48. Sparrow, S., Balla, D., & Cicchetti, D. (1985). *Vineland Adaptive Behavior Scales*. Circle Pines, MN: American Guidance Service, Inc.

49. Stein et al. (1995) as cited in Research findings, *The ADHD Report, 3*(5), p.14.

50. Roizen, N., Blondis, T., Irwin, M., & Stein, M. (1994) as cited in (1995) Research Findings, *The ADHD Report, 3*(3), p. 14.

51. Lemonick, M. (1995). Glimpses of the mind. *Time, 146*(3), pp. 44-52.

52. Sylwester, R. (1994). How emotions affect learning. *Educational Leadership, 52*(2), 60-65.

53. Sylwester, R. (1994). How emotions affect learning. *Educational Leadership, 52*(2), 65.

54. Pilavin & Briar, as cited in Keilitz, I., & Dunivant, N. (1986). The relationship between learning disability and juvenile delinquency: Current state of knowledge. *Remedial and Special Education, 7*(3), 18-26.

55. Brooks, R. (1992, Fall, Winter). Fostering self-esteem in children with ADD: The search for islands of competence. *Chadder*, p. 15.

56. Goldstein, S., & Goldstein, M. (1992). *Hyperactivity: Why won't my child pay attention?* New York: John Wiley & Sons, Inc.

57. Fouse, B. & Brians, S. (1993). Fastback 354: A primer on attention deficit disorder. Bloomington, IN: Phi Delta Kappa Educational Foundation.

58. Bernard, B. (1993). Fostering resiliency in kids. *Educational Leadership, 51*(3), 44-48.

59. Bernard, B. (1995). Fostering resiliency in urban schools. In B. Williams (Ed.), *Closing the achievement gap: A vision to guide change in beliefs and practice* (pp. 65-80). Oak Brook, IL: Urban Education National Network, North Central Regional Educational Laboratory.

60. Katz, M. (1995, November). *From challenged childhood to successful adulthood: Studies in resilience*. Paper presented at the CH.A.D.D. Seventh Annual Conference for Parents, Educators, and Health-Care Professionals, Washington, DC.

61. Bushweller, K. (1995). The resilient child. *The American School Board Journal, 182*(5), 18-23.

62. Viadero, D. (1995 May/June). Research: Against all odds. *Teacher Magazine*, pp. 20-22.

63. Katz, M. (1994 May). From challenged childhood to achieving adulthood: Studies in resilience. *Chadder*, pp. 8-11.

64. Sylwester, R. (1995). *A celebration of neurons: An educator's guide to the human brain*. Alexandria, VA: Association for Supervision and Curriculum Development.

65. Rutter, as cited in Benard, B. (1995). Fostering resiliency in urban schools. In B. Williams (Ed.), *Closing the achievement gap: A vision to guide change in beliefs and practice* (p. 70). Oak Brook, IL: Urban Education National Network, North Central Regional Educational Laboratory.

66. Benard, B. (1995). Fostering resiliency in urban schools. In B. Williams (Ed.), *Closing the achievement gap: A vision to guide change in beliefs and practice* (p. 70). Oak Brook, IL: Urban Education National Network, North Central Regional Educational Laboratory.

67. Gottfredson, D. (1984). *Environmental change strategies to prevent school disruption*. Washington, DC: Department of Justice.

68. Gottfredson, D. (1984). *Environmental change strategies to prevent school disruption* (p. 3). Washington, DC: Department of Justice.

69. Gottfredson, D. (1986). *Promising strategies for improving student behavior* (p. 6). Paper prepared for the Conference on Student Discipline Strategies of the Office of Educational Research and Improvement. Washington, DC: U. S. Department of Education.

70. Chaskin, R., & Rauner, D. (1995). Youth and caring. *Phi Delta Kappan, 76*(9), 667-674.

71. Satterfield, J., Satterfield, B., & Schell, A. (1987). Therapeutic interventions to prevent delinquency in hyperactive boys. *Journal of the American Academy of Child and Adolescent Psychiatry, 26*(1), 56-64.

72. Webb, J., & Latimer, D. (1993). *ERIC Digest: ADHD and children who are gifted*. Reston, VA: ERIC Clearinghouse on Disabilities and Gifted Education.

73. Shaw, G., & Brown, G. (1990). Laterality and creativity concomitants of attention problems. *Developmental Neuropsychology, 6*(1), 39-57.

74. Shaw, G. (1992). Hyperactivity and creativity: The tacit dimension. *Bulletin of Psychonomics Society, 30*(2), pp.157-160.

75. Fiore, T., & Becker, E. (1994). *Promising classroom interventions for students with attention deficit disorders*. Research Triangle Park, NC: Center for Research in Education.

76. Clement-Heist, K., Siegel, S., & Gaylord-Roth, R. (1992). Simulated and in situ vocational social skills training for youths with learning disabilities. *Exceptional Children, 58*(4), 336-345.

77. Struck, S. (1994). Early intervention programs: An encouraging past and promising

This issue of Policy Briefs *was researched and written by Soleil Gregg, AEL staff. Gregg has personal experience with Attention Deficit/Hyperactivity Disorder (ADHD), both as a classroom teacher and a parent.*

This brief is the fourth and final in a series on ADHD, a disorder characterized by excessive degrees of inattention, impulsivity, and hyperactivity. It examines risk factors that contribute to the development of antisocial behavior, as well as protective factors that help children become resilient to risk, especially children with ADHD and learning disabilities. The first brief addresses the legal responsibilities of schools to serve students with ADHD. The second discusses steps to effective intervention. The third brief aims to improve academic outcomes for students with ADHD.

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future. *Contemporary Education*, 65(3), 137-141.

78. Hallowell, E., & Ratey, J. (1994). *Answers to distraction*. New York: Pantheon Books.

79. Eggleston, C. (1995). Learning disability and the justice system. *Their world*. New York: National Center for Learning Disabilities.

80. Jones, C. (1994). Building social skills. *Attention, 1*(1), pp. 17-20.

81. Hallowell, E. (1995). Coaching: An adjunct to the treatment of ADHD. *The ADHD Report, 3*(4), pp. 7-9.

82. Favorite, B. (1995). Coaching for adults with ADD: The missing link between desire for change and achievement of success. *The ADHD Report, 3*(6), pp. 11-12.

83. Gottfredson, G. (1987). American education: American delinquency. *Today's Delinquent* (p. 21). Pittsburgh, PA: National Center for Juvenile Justice.

84. Kohn, A. (1993). *Punished by rewards*. Boston: Houghton Mifflin Company.

85. Gottfredson, D. (1987). Examining the potential of delinquency prevention through alternative education. *Today's Delinquent*, (pp. 87-100). Pittsburgh, PA: National Center for Juvenile Justice.

86. Gardiner, M., Fox, A., Knowles, F., & Jeffrey, D. (1996, May 23). Learning improved by arts training. *Nature, 381*, 284.

87. National Education Commission on Time and Learning. (1994). *Prisoners of time*. Washington, DC: U. S. Government Printing Office.

88. McGrew, K., Thurlow, M., Shriner, J., & Spiegel, A. (1992). Inclusion of students with disabilities in national and state data collection programs. Minneapolis, MN: National Center on Educational Outcomes.

89. Lugg, C., & Boyd, W. (1993). Leadership for collaboration: Reducing risk and fostering resilience. *Phi Delta Kappan, 75*(3), 253-258.

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